GEORGIA MEDICAID
DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

INSTRUCTIONS: Please complete the following information that is applicable to you. If the information requested does not apply check N/A or leave blank. See definitions of ownership and controlling interest below.

DEFINITIONS:

- Ownership interest means the possession of equity in the capital, the stock, or the profits of the provider organization.
- Person with an ownership or control interest means a person or corporation that has a direct or indirect ownership interest totaling 5 percent or more in a provider organization; is an officer, director or partner of the provider organization. The interest may be in a mortgage, deed of trust, note or other obligation secured by the provider organization.

I. Identifying Information

Name of Entity	D/B/A	Provider No.	Telephone No.

Street Address	City, County, State	Zip Code

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under "Remarks" on Page 2. Identify each item number to be continued. *See instructions for definition of ownership and controlling interest above.*

A. Are there individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the program established by Medicare, Medicaid or Social Security Block Grants?

☐ Yes ☐ No

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Medicare, Medicaid or Social Security Block Grants?

☐ Yes ☐ No

III. (a) List names, addresses for individuals, and the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under "Remarks" on Page 2.

Name	Address	EIN

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Other (Specify)
☐ Unincorporated Associations ☐ Corporation

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under "Remarks" on Page 2.

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☐ No

Name	Address	Provider Number

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date ☐ Yes ☐ No

(b) Do you anticipate any change in ownership or control within the year?
If yes, when? ☐ Yes ☐ No

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? ☐ Yes ☐ No

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations ☐ Yes ☐ No

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?
☐ Yes ☐ No

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
☐ Yes ☐ No

Name	Address	EIN

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If Yes, list Name, Address or Corporation and EIN) ☐ Yes ☐ No ☐ N/A

Name	Address	EIN

VIII. List owners of subcontractors that you have had business transactions with totaling more than $25,000 during the past 12 months.

Name	Address	EIN

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title

Signature	Date

REMARKS (add additional sheets if necessary)**:**